803 KAR 25:091. Workers' compensation hospital fee schedule.

RELATES TO: KRS 342.020, 342.035, 342.315
STATUTORY AUTHORITY: KRS 342.020, 342.035, 342.260
NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.035 requires the Executive Director of the Office of Workers' Claims to promulgate administrative regulations to adopt a medical fee schedule for fees, charges and reimbursements under KRS 342.020. KRS 342.020 requires the employer to pay for hospital treatment, including nursing, medical, and surgical supplies and appliances. EO 2008-472, effective June 2, 2008, reorganized the Office of Workers' Claims as the Department of Workers' Claims and established the commissioner, rather than executive director, as the head of the department. This administrative regulation establishes hospital fees for services and supplies provided to workers' compensation patients pursuant to KRS 342.020.

Section 1. Definitions. (1) "Ambulatory surgery center" means a public or private institution that is:
(a) Hospital based or freestanding;
(b) Operated under the supervision of an organized medical staff; and
(c) Established, equipped, and operated primarily for the purpose of treatment of patients by surgery, whose recovery under normal circumstances will not require inpatient care.
(2) "Hospital" means a facility, surgical center, or psychiatric, rehabilitative or other treatment or specialty center which is licensed pursuant to KRS 216B.105.
(3) "Hospital-based practitioner" means a provider of medical services who is an employee of the hospital and who is paid by the hospital.
(4) "Independent practitioner" means a physician or other practitioner who performs services that are covered by the Workers' Compensation Medical Fee Schedule for Physicians on a contract basis and who is not a regular employee of the hospital.
(5) "New hospital" means a hospital which has not completed its first fiscal year.

Section 2. Applicability. This administrative regulation shall apply to all workers' compensation patient hospital fees for each hospital for each compensable service or supply.

Section 3. Calculation of Hospital's Base and Adjusted Cost-to-charge Ratio; Reimbursement. (1)(a) A hospital's base cost-to-charge ratio shall be based on the latest cost report, or HCFA-2552, which has been supplied to the Cabinet for Health and Family Services, Department of Medicaid Services, pursuant to 907 KAR 1:815 and utilized in 907 KAR 1:820 and 1:825 on file as of October 31 of each calendar year.
(b) The base cost-to-charge ratio shall be determined by dividing the net expenses for allocation as reflected on Worksheet A, Column 7, Line 95, plus the costs of hospital-based physicians and nonphysician anesthetists reflected on lines 12, 13, and 35 of Worksheet A-8, by the total patient revenues as reflected on Worksheet G-2 of the HCFA-2552. The adjusted cost-to-charge ratio shall be determined as set forth in paragraph (c) of this subsection.
(c)1. The base cost-to-charge ratio shall be further modified to allow for a return to equity by multiplying the base cost-to-charge ratio by 132 percent except that a hospital with more than 400 licensed acute care beds as shown by the Cabinet for Health and Family Services, Office of Inspector General's Web site or a hospital that is designated as a Level I trauma center by the American College of Surgeons shall have a return to equity by multiplying its base cost-to-charge ratio by 138 percent.
2. If a hospital's base cost-to-charge ratio falls by ten (10) percent or more of the base for one (1) reporting year, the next year's return to equity shall be reduced from 132 percent to 130 percent or 138 percent to 135 percent as determined by subparagraph 1. of this paragraph.
a. This reduction shall be subject to an appeal pursuant to Section 4 of this administrative regulation.
b. Upon written request of the hospital seeking a waiver and a showing of extraordinary circumstances the commissioner may waive the reduction for no more than one (1) consecutive year.
c. The determination of the commissioner shall be made upon the written documents submitted by the requesting hospital.
(d)1. Except as provided in subparagraph 2 of this paragraph, a hospital's adjusted cost-to-charge ratio shall not exceed fifty (50) percent, including the return to equity adjustment.
2. The adjusted cost-to-charge ratio shall not exceed sixty (60) percent for a hospital that:
a. Has more than 400 licensed acute care beds as shown by the Cabinet for Health and Family Services, Office of Inspector General's Website;
b. Is designated as a Level I trauma center by the American College of Surgeons;
c. Services sixty-five (65) percent or more patients covered and reimbursed by Medicaid or Medicare as reflected in the records of the Cabinet for Health and Family Services, Department of Medicaid Services; or
d. Has a base cost-to-charge ratio of fifty (50) percent or more.
(2)(a) Except as provided in paragraph (b) of this subsection, the reimbursement to a hospital for services or supplies furnished to an employee which are compensable under KRS 342.020 shall be calculated by multiplying the hospital's total charges by its adjusted cost-to-charge ratio after removing any duplicative charges, billing errors, or charges for services or supplies not confirmed by the hospital records.
(b) If part of a bill for services or supplies is alleged to be non-compensable under KRS 342.020 and that part of the bill is challenged by the timely filing of a medical fee dispute or motion to reopen, the non-contested portion of the bill shall be paid in accordance with paragraph (a) of this subsection.

Section 4. Appeal of Assigned Ratio. (1) Each hospital subject to the provisions of this administrative regulation shall be notified of its proposed base cost-to-charge ratio by the commissioner by U.S. mail within thirty (30) days of the date the base cost-to-charge ratio is assigned by the Commissioner of the Department of Workers' Claims.
(2)(a) A hospital may request a review of its assigned ratio by filing a written appeal with the commissioner no later than thirty (30) calendar days after the ratio has been assigned and hospital notified of its proposed cost-to-charge ratio.
(b) The determination of the commissioner shall be made upon the written documents submitted by the requesting hospital.

Section 5. Revision of Hospital Cost-to-charge Ratio. (1)(a) The commissioner shall calculate cost-to-charge ratios and notify each hospital of its adjusted cost-to-charge ratio on or before February 1 of each calendar year.

(b) A new hospital shall be assigned a cost-to-charge ratio equal to the average adjusted cost-to-charge ratio of all existing in-state acute care hospitals until it has been in operation for one (1) full fiscal year.

(c) A hospital that does not file Worksheets A and G-2 of HCFA 2552 shall be assigned a cost-to-charge ratio as follows:

1. A psychiatric, rehabilitation, or long-term acute care hospital shall be assigned a cost-to-charge ratio equal to the average adjusted cost-to-charge ratio of all in-state acute care hospitals;

2. An ambulatory surgery center shall be assigned a cost-to-charge ratio equal to:

a. Seventy (70) percent of the average adjusted cost-to-charge ratio of all acute care hospitals located in the same county as the ambulatory surgery center; or

b. If no acute care hospital is located in the county of the ambulatory surgery center, seventy (70) percent of the average adjusted cost-to-charge ratio of all acute care hospitals located in counties contiguous to the county in which the ambulatory surgery center is located; or

c. The adjusted cost-to-charge ratio of the base hospital if:

i. The center is hospital based;

ii. Is a licensed ambulatory surgery center pursuant to 902 KAR 20:105; and

iii. Is a Medicare provider based entity; and

3. All other hospitals not specifically mentioned in subparagraphs 1 or 2 of this paragraph shall be assigned a cost-to-charge ratio equal to:

a. The average adjusted cost-to-charge ratio of all acute care hospitals located in the same county as the facility; or

b. If there are no hospitals in the county, the average of all acute care hospitals located in contiguous counties.

(2) An assigned cost-to-charge ratio shall remain in full force and effect until a new cost-to-charge ratio is assigned by the commissioner.

Section 6. Calculation for Hospitals and Ambulatory Surgery Centers Located Outside the Commonwealth of Kentucky. (1) A hospital or ambulatory surgery center located outside the boundaries of Kentucky shall be deemed to have agreed to be subject to this administrative regulation if it accepts a patient for treatment who is covered under KRS Chapter 342.

(2) The base cost-to-charge ratio for an out-of-state hospital shall be calculated in the same manner as for an in-state hospital, using Worksheets A and G-2 of the HCFA 2552.

(3) An out-of-state ambulatory surgery center having no contiguous Kentucky counties shall be assigned a cost-to-charge ratio equal to seventy (70) percent of the average adjusted cost-to-charge ratio of all existing in-state acute care hospitals.

(4) An out-of-state ambulatory surgery center having one (1) or more contiguous Kentucky counties shall be assigned a cost-to-charge ratio in accordance with Section 5(1)(c)2.b. of this administrative regulation.

Section 7. Reports to be Filed by Hospitals. Each bill submitted by a hospital pursuant to this administrative regulation shall be submitted on a statement for services, Form UB-04 (Formerly UB-92), as required by 803 KAR 25:096.

Section 8. Billing and Audit Procedures. (1) A hospital providing the technical component of a procedure shall bill and be paid for the technical component.

(2)(a) An independent practitioner providing the professional component shall bill for and be paid for the professional component.

(b) An independent practitioner billing for the professional component shall submit the bill to the insurer on the appropriate statement for services, HCFA 1500, as required by 803 KAR 25:096.

Section 9. Miscellaneous. (1) A new hospital shall be required to file a letter with the commissioner setting forth the start and end of its fiscal year within ninety (90) days of the date it commences operation.

(2)(a) An independent practitioner who does not receive direct compensation from the contracting hospital shall use the statement for services defined by 803 KAR 25:096 when billing for professional services and shall be compensated pursuant to the Kentucky Workers' Compensation Medical Fee Schedule for Physicians incorporated by reference in 803 KAR 25:089.

(b) An independent practitioner who is directly compensated for services by the contracting hospital shall not bill for the service, but shall be compensated pursuant to the practitioner's agreement with the hospital.

(c) The hospital may bill for the professional component of the service under the Kentucky Workers' Compensation Medical Fee Schedule for Physicians if the independent practitioner is directly compensated for services by the contracting hospital.

(3) A hospital-based practitioner shall not bill for a service he performs in a hospital if the service is regulated by 803 KAR 25:089, but he shall receive payment or salary directly from the employing hospital.

Section 10. Incorporation by Reference. (1)The following material is incorporated by reference:

(a) Form UB-40, 10-23-06; and

(b) HCFA 1500, 12-90.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Workers' Claims, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. (19 Ky.R. 1026; Am. 1396; 1755; eff. 2-2-93; 21 Ky.R. 1569; 1884; 2130; eff. 2-9-95; 23 Ky.R. 2619; 2988; eff. 2-10-97; TAm eff. 8-9-2007; 35 Ky.R. 1907; 2304; 2435; eff. 6-5-09.)